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Issue date: 10Sep2002

CASE NOS.: 2001-BLA-01092
2001-BLA-01093

IN THE MATTER OF:

FRANCES E. POOLE, Widow of
STERLING POOLE, Deceased Miner

Claimants

v.

FREEMAN UNITED COAL MINING CO.

Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS

Party-in-Interest

APPEARANCES:[1]

Frances E. Poole, Pro Se

John A. Washburn, Esq.
Chicago, Illinois

For the Employer

BEFORE: Lee J. Romero, Jr.
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

[1] The Director, Office of Workers' Compensation Programs, was not present or represented at the hearing.

This is a decision and order arising out of two claims for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, (hereinafter referred to as "the Act") and the regulations thereunder at Title 20 of the Code of Federal Regulations (CFR). Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On July 27, 2001, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX-48).[2] A formal hearing on this matter was conducted on January 14, 2002, in Metairie, Louisiana, by the undersigned Administrative Law Judge.

All parties were afforded the opportunity to call and examine witnesses, to cross-examine witnesses and to present evidence, as provided in the Act and the above-referenced regulations. Post-hearing memoranda were received from Claimant and Employer.

ISSUES

The issues in this case are:

1. Whether the miner had pneumoconiosis as defined by the Act and regulations;

2. Whether the miner's pneumoconiosis arose out of coal mine employment;

3. Whether the miner's disability was due to pneumoconiosis; and

4. Whether the miner's death was due to pneumoconiosis.

(DX-46, 47; Tr. 21-24).

Based upon a thorough analysis of the entire record in this

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[2] In this Decision, "CX-" refers to Claimant's exhibits, "DX-" refers to the Director's Exhibits, "EX-" refers to the Employer's Exhibits, "ALJX-" refers to the Administrative Law Judge's Exhibits, and "Tr." refers to the official transcript of this proceeding.

case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT

Procedural History:

The miner, Sterling Poole, filed an application for Black Lung benefits on January 20, 1999. (DX-1). On October 19, 1999, the District Director found Mr. Poole entitled to benefits. (DX-25). The employer controverted the award on October 29, 1999. (DX-26). On November 16, 1999, the claim was referred to the Office of Administrative Law Judges. (DX-28). Thereafter, Mr. Sterling died on November 15, 2000, and the claim was remanded on December 14, 2000 to allow Mrs. Poole to file a survivor's claim. (DX-30).

Mrs. Poole filed a survivor's claim on December 14, 2000. (DX-31). The District Director found Mrs. Poole entitled to benefits on June 1, 2001. (DX-43). The employer requested a hearing before the Office of Administrative Law Judges on June 25, 2001. (DX-44). On July 27, 2001, the claims were transferred to the Office of Administrative Law Judges. (DX-46). The undersigned conducted a formal hearing in this matter on January 14, 2002 in Metairie, Louisiana.

At the hearing, I reserved ruling on Claimant's Exhibits 1(b) through 1(e). (Tr. 14). These exhibits include a copy of 20 C.F.R. § 718.205 and documents downloaded from the internet regarding the definition of pneumoconiosis and its symptoms. Although the rules of evidence are not strictly adhered to in this administrative matter, the proffered evidence should at least be relevant. Because I find that Claimant's Exhibits 1(b) through 1(e) do not tend to make the existence of any fact that is of consequence to the determination of these claims more or less probable than it would be without the evidence, I find the exhibits irrelevant and, therefore, inadmissible.

Background:

Mr. Poole was born on September 25, 1929 and was seventy-one years old at the time of his death on November 15, 2000. (DX-1, 35). Mr. Poole completed three years of college. (DX-1). He married Frances Eloise Shaw on November 12, 1955, and she remained his only dependent. (DX-1, 33). Mrs. Poole was born September 20, 1937, and has no dependents. (DX-1, 34).

Mrs. Poole provided a three-page, handwritten letter describing her husband's condition prior to his death. (CX-1). I will quote some of the most salient points:

> Sterling was a proud and independent person before he became ill. His independence was taken from him due to his illness.
>
> In 1997 Sterling noticed a change in his health, from 1977 to 1999 and until his death on Nov. 15, 2000 the disease rapidly progressed. He had to depend on machines and medication to keep him alive.
>
> He was unable to drive or go anywhere without assistance, due to his breathing problem and heart condition.
>
> When Sterling retired at 62 years old it was not because of retirement age as stated in one report. It was due to health with severe coughing spells. At times he would black out and rather [than] be a danger to others or himself, he retired.
>
> Sterling was hospitalized 3 times due to his illness. Two times he came home. His health never improved or the illness cured. All that could be done and provided was comfort measures.
>
> The third hospitalization Sterling passed away.
>
> It [has] been stated that due to my husband's smoking it was the contributing factor in his death. I disagree with it.
>
> There is medical data stating smoking does not increase the prevalence of this disease, the area of the mine where the miner worked involving the dust is a contributing factor, and pneumoconiosis . . . [is a] chronic disease of the lung. "Black Lung" can take up to 25 years to develop after leaving the mines.
>
> As the disease progresses the person developes [sic] loss of lung function and a heart deficiency called cor pulmonale which develop[s] in severe cases.
>
> It is documented Sterling had all the signs and symptoms of Black Lung. His illness progressed rapidly to the point where he was on oxygen 24 hours a day,

> loss of weight and appetite, had difficulty sleeping and was unable to walk any distance.
>
> I read the reports from doctors Freeman Coal Co. hired. I am not saying they aren't qualified in their field. I do disagree with their reports on their findings on Sterling.
>
> They never met Sterling, knew him as a person, or treated my husband for his illness. All they knew was medical reports and x-rays of Sterling.

Mrs. Poole testified at the hearing that Mr. Poole began coal mining in 1949, before she even knew him. He worked for Old Ben Coal company. (Tr. 27). After they were married, he worked for Inland Steel from 1970 to 1975. He then worked two years for Mrs. Poole's father in Pennsylvania, strip mining. Thereafter, Mr. Poole went to work for Freeman Coal Company for five years, ending in 1982. (Tr. 27-28). He was a continuous mine operator, and the masks he wore were always dirty at the end of the day. (Tr. 29). The employer did not contest Mr. Poole's assertion of fourteen years of coal mine employment, and I find that he was employed as a coal miner for fourteen years, lastly as a continuous miner operator. (Tr. 46-47).

In 1997, the miner began to experience shortness of breath, feeling "down in the dumps," and developed a cough. (Tr. 31). Mrs. Poole testified that her husband was smoking when she first met him in 1955 and continued to smoke even after he left coal mining. (Tr. 31-32). However, according to Mrs. Poole, Mr. Poole was never a heavy smoker because he could not smoke in the mines, so during his coal mining years, he smoked only two or three cigarettes a day. (Tr. 32). Mrs. Poole stated that her husband was hospitalized three times for his breathing problems, first in March 1999. (Tr. 33). He was told that he only had 30% lung capacity remaining. (Tr. 34). During the process of undergoing respiratory treatments, Mr. Poole suffered a heart attack in 1998 and was told it was related to his lungs. (Tr. 34). He was treated with antibiotics, steroids, breathing treatments, and oxygen. (Tr. 35). His family physician was Dr. Winkler. (Tr. 36).

MEDICAL EVIDENCE

A. Chest X-Rays:

X-ray Date	Exhibit No.	Physician	Reading
9-28-1982	EX-36	Dr. Hutchinson	A few scattered calcified

			granuloma in both lungs; no evidence of pulmonary infiltrates or pleural effusions
8-25-1997	DX-42	Dr. Kerber	Severe chronic obstructive pulmonary disease; right upper lobe scarring; aortic atherosclerotic calcification
8-25-1997	DX-42	Dr. Main[3]	Negative for pneumoconiosis; a fibrocalcific density in right apex consistent with granulomatous change; emphysema
8-25-1997	DX-42	Dr. Wheeler[4]	No evidence of silicosis or coal workers' pneumoconiosis; moderate emphysema with hyperinflation; minimal healed tuberculosis with calcified granulomata and focal fibrosis in posterior right apex and few tiny calcified granulomata in periphery left upper lobe and right lower lateral lung
10-2-1997	DX-42	Dr. Kerber	Old granulomatous disease; severe chronic obstructive pulmonary disease
10-2-1997	DX-42	Dr. Main	Negative for pneumoconiosis; a fibrocalcific density in right apex consistent with granulomatous change;

[3] Dr. Main is a "B" reader. A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. Physicians' qualifications are a matter of public record at the HHS National Institute of Occupational Safety and Health (NIOSH) reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.51). Consequently, greater weight is given to a diagnosis by a "B" Reader. See Blackburn v. Director, OWCP, 2 B.L.R. 1-153 (1979).

[4] Dr. Wheeler is a "B" reader and Board-certified in radiology.

			emphysema
10-2-1997	DX-42	Dr. Wheeler	No evidence of silicosis or coal workers' pneumoconiosis; moderate emphysema with hyperinflation; minimal healed tuberculosis with calcified granulomata and focal fibrosis in posterior right apex and few tiny calcified granulomata in periphery left upper lobe and right lower lateral lung
6-15-1998	DX-42	Dr. Williams	Moderate to severe bilateral chronic obstructive pulmonary disease with scattered bilateral granuloma type nodules and scars; no definite acute or neoplastic chest disease or cardiomegaly
6-15-1998	EX-10	Dr. Wheeler	No evidence of silicosis or CWP; moderate emphysema; minimal healed TB more likely than healed histoplasmosis with focal fibrosis and small calcified granuloma lower right apex
6-15-1998	EX-11	Dr. Worrell[5]	0/1; r/r; 4 zones; many of the round opacities are calcified and may represent granulomta versus pneumoconiosis
3-15-1999	DX-15	Dr. Preger[6]	2/1; t/q; 3 zones; type A large opacities; bilateral healed granulomatous disease, question histoplasmosis; ill-defined large opacity in left lower lung; appearance is atypical for both CWP and asbestosis; history is important
3-15-1999	EX-12	Dr. Wheeler	No evidence of silicosis or CWP; ill-defined infiltrate left lower lung near apex of heart compatible with edema or pneumonia or fibrosis;

[5] Dr. Worrell is a "B" reader and Board-certified in radiology.

[6] Dr. Preger is a "B" reader.

			moderate emphysema; minimal healed TB with scars in right apex and few scattered calcified granulomata
3-15-1999	EX-13	Dr. Worrell	1/1; q/p; 6 zones; many of these nodules are calcified and could represent granulomatous disease vs. pneumoconiosis; the coalescent pattern at the left base is non-specific, but pneumonia should be considered
3-16-1999	EX-14	Dr. Wheeler	Ill-defined infiltrate or fibrosis left lower lung; emphysema; minimal healed TB with scar and calcified granuloma right apex and few calcified granulomata in both lungs and probably in left hilum
3-16-1999	EX-15	Dr. Worrell	1/0; q/r; 2 zones; many of the opacities are calcified and may represent granulomata vs. pneumoconiosis
3-20-1999	DX-42	Dr. Miller	Pneumonia; chronic obstructive pulmonary disease; no evidence of active/acute pulmonary disease
3-20-1999	EX-16	Dr. Worrell	0/1; r/r; 4 zones; many of the round opacities are calcified and may represent granulomata vs. pneumoconiosis
3-20-1999	EX-17	Dr. Wheeler	No evidence of silicosis or CWP; possible focal infiltrate in anterior inferior right middle lobe; moderate emphysema with hyperinflation; minimal healed TB with subtle right apical pleural thickening, focal fibrosis, and probable small calcified granuloma lower right apex and few tiny calcified granulomata
9-13-1999	EX-33	Dr. Wester	Chronic obstructive pulmonary disease; scattered calcified granulomas; right apical density which may represent an

			area of parenchymal scarring, but a pulmonary nodule cannot be excluded
9-13-1999	EX-18	Dr. Wheeler	No evidence of silicosis or coal workers' pneumoconiosis; moderate emphysema; minimal healed TB with coarse scar and probable small calcified granuloma
11-19-1999	DX-42	Dr. Matthews[7]	0/1; s/t; 4 zones; emphysema; no acute cardiopulmonary disease
11-19-1999	EX-21	Dr. Hippensteel[8]	Negative for pneumoconiosis; a few scattered calcified granulomas; emphysema
11-19-1999	EX-22	Dr. Castle[9]	Negative for pneumoconiosis; granulomatous disease; emphysema
11-19-1999	EX-20	Dr. Wheeler	No evidence of silicosis or coal workers' pneumoconiosis; moderate emphysema; minimal healed TB with coarse scar and probable small calcified granuloma
7-21-2000	EX-37	Dr. Bodin	No evidence of acute cardiopulmonary process; tiny granuloma left upper lung
7-21-2000	EX-25	Dr. Wheeler	Moderate hyperinflation lungs with decreased upper lung markings compatible with emphysema; small calcified granuloma below right apex is partly hidden; probably healed TB; negative for pneumoconiosis

[7] Dr. Matthews is a "B" reader and Board-certified in radiology.

[8] Dr. Hippensteel is a "B" reader.

[9] Dr. Castle is a "B" reader.

7-21-2000	EX-26	Dr. Scott[10]	Negative for pneumoconiosis; calcified granulomata right apex and lateral left upper lung; hyperinflation lungs compatible with emphysema
7-25-2000	EX-37	Dr. Bodin	Chronic obstructive pulmonary disease, possible small pleural effusions
7-25-2000	EX-27	Dr. Wheeler	No silicosis or CWP; emphysema with moderate hyperinflation; 1 cm calcified granuloma in posterior inferior right apex and tiny calcified granuloma in posterolateral periphery left upper lobe and one in inferior lateral right lung compatible with healed TB more likely than healed histoplasmosis
7-25-2000	EX-28	Dr. Scott	Negative for pneumoconiosis; hyperinflation lungs compatible with emphysema; calcified granulomata right apex, lateral left upper lung and lateral right lower lung
11-2-2000	EX-29	Dr. Wheeler	No silicosis or CWP; moderate emphysema with hyperinflation; 1 cm calcified granuloma in posterior inferior right apex and tiny calcified granuloma in posterolateral periphery left upper lobe and one in inferior lateral right lung compatible with healed TB more likely than healed histoplasmosis
11-2-2000	EX-30	Dr. Scott	Negative for pneumoconiosis; hyperinflation lungs compatible with emphysema; calcified granulomata right apex, lateral left upper lung and lateral right lower lung
11-15-2000	DX-44	Dr. Donner	Chronic obstructive pulmonary disease with bilateral parenchymal scarring; evidence

[10] Dr. Scott is a “B” reader and Board-certified in radiology.

of prior granulomatous disease; atherosclerosis of the thoracic aorta

B. CT Scan

Mr. Poole underwent a chest CT scan on September 29, 1999. (EX-23). Dr. Wheeler interpreted the scan, opining that there was no evidence of pneumoconiosis. He found "moderate emphysema with hyperinflation lungs" and a "1.4-cm calcified granuloma in the posterior inferior apical portion" of the right upper lung, and a "3-mm calcified granuloma in posterolateral left upper lung compatible with healed tuberculosis." Dr. Scott also interpreted the CT scan. He found a 1-cm calcified granuloma and linear scars in the posterior right upper lung; a small calcified granuloma in the lateral left upper lung; emphysema with hyperinflation and scattered bullous changes; and aortic and coronary artery calcification. He found no evidence of silicosis/coal workers' pneumoconiosis. (EX-24).

C. Pulmonary Function Tests:

Date	Ex. No.	Age/ Height	FEV_1[11]	FVC[12]	MVV[13]	Valid	Qualifies
8-20-1997	EX-32	67/72"	0.84	1.98	28	—	yes
(post-bronchodilator)			0.87	2.31	—	—	yes
Interpretation: Moderate obstructive pulmonary impairment; possible restrictive ventilatory defect							
6-15-1998	EX-31	68/71"	0.51	1.36	16	—	yes
(post-bronchodilator)			0.58	1.97	—	—	yes
3-15-1999	EX-35	69/69.5"	0.75	1.87	—	yes	yes
Interpretation: Severe obstructive disease; restrictive disease cannot be excluded; post-bronchodilator not performed							
Found acceptable by Dr. Timothy Kennedy on July 28, 1999. (D-14). Dr. Kennedy is board-certified in internal medicine, pulmonary diseases, and critical care medicine.							
11-19-1999	DX-42	70/69.5"	0.52	2.02	18	—	yes
Interpretation: Severe obstruction; moderate overinflation; diffusion capacity							

[11] Forced expiratory volume in one second.

[12] Forced vital capacity.

[13] Maximum voluntary ventilation.

is mildly decreased; MVV is severely decreased.

D. Arterial Blood Gas Studies:

Test Date	Exhibit No.	pCO_2	pO_2	Qualifies	At rest/ After exercise
10-2-1997	EX-32	58.9	59.3	yes	At rest
6-15-1998	EX-31	60	55	yes	At rest
1-11-1999	EX-31	69	46	yes	At rest
3-15-1999	DX-13	62.7	52.9	yes	At rest
Found valid by Dr. Timothy Kennedy on July 28, 1999. (DX-14)					
11-19-1999	DX-42	61	64	yes	At rest
11-15-2000	DX-44	130	-	yes	At rest

E. Medical Opinions:

On March 15, 1999, Mr. Poole was examined by Dr. Cullen A. Hebert. (DX-12). He considered 15 years of underground coal mine employment, a history of smoking as much as three packs of cigarettes a day from the age of 35-40, a medical history, complaints of a productive cough and some wheezing, an x-ray, a pulmonary function study, a blood gas study, and a physical examination that revealed marked hyper-expansion of the chest. Dr. Hebert diagnosed chronic obstructive pulmonary disease of the emphysematous type due to smoking. He also found pneumoconiosis based on a chest x-ray. Dr. Hebert did not address the miner's disability.

Records from North Oaks Hospital show that Mr. Poole presented on March 16, 1999 with chronic obstructive pulmonary disease with acute exacerbation and pneumonia. (DX-42; EX-31). Dr. M. Laughlin Winkler attended him and considered a medical history, a history of smoking half a pack of cigarettes a day for over sixty years, an x-ray, and the results of a physical examination, which showed wheezing and dullness to percussion. Dr. Winkler diagnosed severe end-stage emphysema with left lower lobe pneumonia, with basilar pneumonia, cor pulmonale with supraventricular tachycardia, and pulmonary insufficiency with oxygen saturation on room air at 89%. He admitted Mr. Poole to the hospital.

Dr. W. Brooks Emory examined the miner on November 19, 1999. (DX-42). He considered a total of 23 years of underground coal mine employment, lastly as a machine operator, a medical history, symptoms of shortness of breath and a cough, as well as exertional dyspnea, and a history of smoking since the age of 19.

Dr. Emory also took into account the results of a chest x-ray, a pulmonary function study, a blood gas study, and a physical examination, which showed decreased breath sounds throughout all lung fields. He opined that the miner had pulmonary emphysema secondary to cigarette consumption and a physiological impairment of severe obstruction with hyperinflation and air trapping. He concluded that Mr. Poole did not have pneumoconiosis. He noted respiratory failure but did not address whether the claimant was totally disabled.

Dr. Emory later reviewed the medical records of his examination of the miner in a report dated June 19, 2000, at the employer's behest. (EX-2). He explained that the November 19, 1999 chest x-ray was not consistent with pneumoconiosis, but compatible with emphysema, and that the "carboxy hemoglobin level" of the miner was consistent with active cigarette smoking. He opined, with medical certainty, that the miner's pulmonary impairment was strictly a consequence of his emphysema due to fifty years of smoking.

On June 13, 2000, Dr. Gregory J. Fino reviewed the medical evidence of record. (EX-3). He considered the variously reported smoking histories, 13 years of coal mine employment, lastly as a continuous miner operator, hospital records from September 1982 and March 1999, clinic records from August 1997 to April 1998, Dr. Winkler's records, the reports of Drs. Hebert and Emory, 21 x-ray reports, four pulmonary function studies, and five blood gas studies. Dr. Fino concluded that the evidence was insufficient to justify a diagnosis of simple coal workers' pneumoconiosis. In his opinion, the miner did not suffer from an occupationally acquired pulmonary condition. He found a disabling respiratory impairment due to smoking and ruled out coal mine dust inhalation as a cause of that impairment. Even assuming the presence of pneumoconiosis, Dr. Fino would not find that his pulmonary impairment was due in any part to that disease.

Dr. Fino provided a supplemental report dated December 13, 2001. (EX-4). He reviewed five additional x-ray readings, office notes from March 15, 1999 to June 23, 1999, the March 16, 1999 discharge summary, the death summary, the death certificate, and the autopsy protocol. He found that the additional data further strengthened his opinion. He noted that the autopsy did not show evidence of pneumoconiosis. He pointed out that macules must be seen in order to diagnose the disease of pneumoconiosis, and even though the prosector found "slight" anthracosilicosis, she specified that no macules were seen. Dr. Fino opined the autopsy revealed the miner had "minimal to possibly no dust

deposition" in his lungs. Thus, he concluded that coal mine dust exposure did not contribute to the miner's disabling respiratory impairment. He further asserted that the miner's respiratory death was due to smoking and was not caused, contributed to, or hastened by coal mine dust inhalation.

Mr. Poole was hospitalized at St. Tammany Parish Hospital from July 21, 2000 to July 27, 2000. (EX-37). He was attended by Dr. Joseph Landers, who considered a "history of black lung," complaints of shortness of breath for a week and a cough, a history of smoking one-half pack of cigarettes a day for over 60 years, a medical history, an unspecified history as a coal miner, an x-ray, an EKG, and a physical examination, which showed diffuse end expiratory wheeze bilaterally and poor air movement. The discharge diagnoses were asthmatic bronchitis and a "history of black lung" secondary to working in the coal mines.

Mr. Poole was brought to North Oaks Hospital on November 15, 2000 and was seen by Dr. Susan Zacharia. (DX-44). He presented with severe respiratory distress and failure. Dr. Zacharia considered a history of chronic obstructive pulmonary disease, a chest x-ray, a blood gas study, and the results of a physical examination. Mr. Poole died on the same day, and Dr. Zachaira's final diagnoses were respiratory failure, exacerbation of chronic obstructive pulmonary disease, and end-stage emphysema.

The death certificate was signed by Patricia Davidson, a registered nurse and coroner. (DX-35). She listed the cause of death as unspecified natural causes.

Following Mr. Poole's death, an autopsy limited to the chest was performed by Dr. Mina A. Gabrawy on November 21, 2000. (DX-36). Both a gross and a microscopic examination were made. Microscopically, Dr. Gabrawy found:

> Display moderate congestion. Multiple alveoli display hemosiderin laden macrophages. Sections of the upper lobes display dilated air sacs with floating septa. Bronchi display focal infiltrates by neutrophils with fibrin enmeshed neutrophils partially filled the lumina of multiple bronchi and infiltrate the adjacent pulmonary parenchyma with areas of alveolar hemorrhage and fibrin deposition. Small amount of dark gray to black and brown pigment is deposited within alveolar septa. No macules are seen. The granuloma noted in sections of the right hilar node displays central caseation.

Her final diagnoses were: (1) coronary atherosclerosis, marked; (2) pulmonary congestion, marked; (3) bilateral bronchopneumonia; and (4) slight anthracosilicosis, although no macules were seen.

Dr. John P. Kress reviewed medical evidence and provided a report dated December 20, 2001, at the behest of Employer. (EX-5). He considered 14 years of coal mine employment, a 52-year smoking history, a medical history, several x-ray readings, four pulmonary function studies, a blood gas study, a chest CT scan reading, Dr. Hebert's report, hospital records, and the autopsy report. He opined that the miner suffered from severe emphysema from longstanding tobacco abuse. While he recognized an association between coal dust exposure and emphysema, he relied upon the autopsy which showed no evidence of the characteristic lesion of coal workers' pneumoconiosis–centriacinar emphysema in combination with coal macules–to conclude that Mr. Poole did not suffer from coal workers' pneumoconiosis. Dr. Kress specified that he believed the autopsy prosector's diagnosis of "slight anthrasilicosis" was an incidental finding because she did not find any coal macules, and there was no mention of interstitial fibrosis, coal nodules, muscular pulmonary arteries surrounded by coal dust, subpleural dust deposits, hilar or mediastinal lymph node enlargement, or tattooing of the parietal lymphatic channels by coal dust. Likewise, he found no evidence to suggest that pneumoconiosis hastened, caused, or contributed to the miner's death. Dr. Kress is board-certified in internal medicine, pulmonary medicine, and critical care medicine.

DISCUSSION

Miner's Claim

Applicable Law:

The claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, claimant-miner must establish, by a preponderance of the evidence, that he is totally disabled due to pneumoconiosis arising out of coal mine employment. See 20 C.F.R. §§ 719.3, 718.202, 718.203, 718.204; Gee v. W.G. Moore, 9 B.L.R. 1-4, 1-5 (1986); Roberts v. Bethlehem Mines Corp., 8 B.L.R. 1-211, 1-212 (1985). Failure to establish any of these elements precludes entitlement. Anderson v. Valley Camp of Utah, Inc., 12 B.L.R. 1-111, 1-112 (1989); Trent v. Director, OWCP, 11 B.L.R. 1-26, 1-27 (1987).

Pneumoconiosis:

Since claimant's current application was filed after March 31, 1980, this claim will be considered under the provisions of Part 718. In establishing entitlement to benefits, claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. See Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations at § 718.201:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) "Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2002).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence.

In this case, there are 33 readings of 13 separate x-rays. Five of these readings are by "B" readers, whose interpretations merit great weight. Nineteen of these readings are by physicians who are both board-certified radiologists and "B" readers. Thus, their readings are entitled to even greater weight. Scheckler v. Clinchfield Coal Co., 7 BLR 1-128 (1984). There are a total of three positive readings.

The first x-ray was taken on September 28, 1982 and was not found to be positive for pneumoconiosis. The film was not reviewed again.

The next two x-rays were taken August 25, 1997 and October 2, 1997. The original interpreter of each, Dr. Kerber, did not make a finding of pneumoconiosis. The films were also read by Dr. Main, a "B" reader, and Dr. Wheeler, a "B" reader who is also a board-certified radiologist. Both physicians specifically found the x-rays negative for pneumoconiosis. Based on the superior credentials of Drs. Main and Wheeler, I consider these two x-rays negative.

The June 15, 1998 x-ray was interpreted by Dr. Williams, who has no particular credentials for reading x-rays. He did not diagnose pneumoconiosis. Dr. Wheeler and Dr. Worrell, both dually certified readers, interpreted the x-ray as negative for pneumoconiosis. Based on their excellent qualifications, I find this x-ray negative.

The March 15, 1999 x-ray was originally read by Dr. Preger, a "B" reader. She not only found category two pneumoconiosis, but also complicated pneumoconiosis in the form of size A large opacities. She commented, however, that the appearance was atypical for coal workers' pneumoconiosis. However, in Cranor v. Peabody Coal Co., 22 BLR 1-1 (1999), the Benefits Review Board held that an interpreting physician's comment that pneumoconiosis

found on x-ray was not coal workers' pneumoconiosis did not affect her diagnosis of the disease under § 718.202(a)(1), "but merely addresses the source of the diagnosed pneumoconiosis." Therefore, I consider Dr. Preger's reading positive for the disease. While Dr. Wheeler, a dually certified reader, read the film as negative, Dr. Worrell, an equally qualified radiologist and "B" reader, confirmed Dr. Preger's positive diagnosis. Consequently, I consider this particular x-ray positive for pneumoconiosis.

The March 16, 1999 x-ray was read by Dr. Wheeler as negative but by Dr. Worrell as positive, although he found a somewhat lesser degree of the disease than in the previous x-ray. Because the evidence is equally divided concerning this particular x-ray, I consider it negative.

The March 20, 1999 x-ray was read by Dr. Miller, who did not diagnose pneumoconiosis. Drs. Worrell and Wheeler read the film and both found it negative for the disease. Consequently, I find this film negative.

Dr. Wester, whose credentials are not of record, interpreted the September 13, 1999 x-ray and did not find it showed pneumoconiosis. Dr. Wheeler read the film and confirmed that it was negative for pneumoconiosis. Therefore, I find this x-ray negative.

The November 19, 1999 x-ray was interpreted by two "B" readers, Drs. Hippensteel and Castle, and by two dually certified readers, Drs. Matthews and Wheeler. All four agreed that the film was negative for pneumoconiosis. Consequently, I adopt their findings.

The July 21, 2000 and July 25, 2000 x-rays were each read by a hospital radiologist, Dr. Bodin, whose credentials are not of record. He did not diagnose pneumoconiosis. Both films were read by Drs. Wheeler and Scott, both of whom are dually certified readers. Both Dr. Wheeler and Dr. Scott found the two x-rays negative for pneumoconiosis. Thus, I also consider this x-ray negative.

The final x-ray, dated November 15, 2000, was first read by Dr. Donner, whose qualifications are not of record. His interpretation did not include a diagnosis of pneumoconiosis. Drs. Wheeler and Scott read the film and found that it was negative. I, therefore, consider this final x-ray negative.

I also note that Mr. Poole underwent a CT scan on September

29, 1999. It was interpreted by Dr. Wheeler and Dr. Scott. Neither found any evidence of pneumoconiosis.

In summary, there are three positive readings and 30 negative readings. The three positive readings come from well-qualified interpreters. However, the overwhelming number of the most highly qualified readers found the x-rays negative. Furthermore, although I found the March 15, 1999 hospital x-ray positive, the seven more recent x-rays were negative, including one x-ray taken just a day after the March 15, 1999 x-ray and another taken just five days after. Moreover, the six most recent x-rays were unanimously found negative. Furthermore, the CT scan was found negative for pneumoconiosis. Based on the above analysis, the majority of readings by the best-qualified interpreters, and the most recent x-ray evidence, I find that the x-ray evidence overwhelmingly does not support a finding of coal workers' pneumoconiosis pursuant to § 718.201(a)(a). Goss v. Eastern Associated Coal Co., 7 B.L.R. 1-400 (1984).

(2) A biopsy or autopsy conducted and reported in compliance with § 718.106 may also be the basis for finding the existence of pneumoconiosis. 20 C.F.R. § 718.202(a)(2). While no biopsy was performed, a partial autopsy, limited to the lungs, was performed.

Dr. Gabrawy, who performed the limited autopsy, diagnosed anthracosilicosis despite not finding any coal macules either grossly or microscopically. No other physician viewed the autopsy slides, but Dr. Fino and Dr. Kress reviewed the autopsy protocol. Both pointed out that pathologically, because no macules were seen, the diagnosis of anthracosilicosis could not properly be made.

While I recognize the opinions of Drs. Fino and Kress regarding the necessity of finding macules on autopsy in order to merit a diagnosis of pneumoconiosis, neither of these physicians is a pathologist, and neither reviewed the slides. It is reasonable to assign greater weight to the opinion of the physician who performed the autopsy over the opinions of others who reviewed her findings without reviewing the slides. Terlip v. Director, OWCP, 8 BLR 1-363 (1985); Fetterman v. Director, OWCP, 7 BLR 1-688 (1985). Despite Dr. Gabrawy's statement that macules were absent, she felt that the gross and microscopic examinations of Mr. Poole's lung tissue warranted a diagnosis of anthracosilicosis, which is included in the definition of pneumoconiosis. 20 C.F.R. § 718.201. I choose to rely on Dr. Gabrawy's report and thus, find that the autopsy evidence tends

to support a finding of pneumoconiosis.

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. Section 718.305 is not applicable to claims filed after January 1, 1982. The presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Under 20 C.F.R. § 718.304, there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if he is suffering from a chronic dust disease of the lung, which, when diagnosed by x-ray, yields one or more large opacities and would be classified in Category A, B, or C.

In this case, Dr. Preger, a “B” reader, found size A large opacities on the March 15, 1999 x-ray. She commented, however, that the appearance was atypical for coal workers’ pneumoconiosis. Furthermore, among the other 32 x-ray readings, no other physician found large opacities. Dr. Worrell, who also found the March 15, 1999 x-ray positive for pneumoconiosis, did not find any large opacities, and he is both a “B” reader and a board-certified radiologist. Because I find that even Dr. Preger questioned the existence of large opacities due to pneumoconiosis, Dr. Worrell did not make such a finding on the same x-ray, and no other physicians suggested the presence of complicated pneumoconiosis, I conclude that the evidence does not establish the existence of complicated pneumoconiosis. Therefore, the claimants are not entitled to the irrebuttable presumption of § 718.304, and the evidence does not establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

This section requires a weighing of all relevant medical evidence to ascertain whether or not claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a

reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. Oggero v. Director, OWCP, 7 B.L.R. 1-860 (1985).

Dr. Hebert diagnosed pneumoconiosis. Dr. Landers diagnosed a "history of black lung." The records from Drs. Winkler and Zacharia do not address the presence or absence of pneumoconiosis. Drs. Emory, Fino, and Kress opined that Mr. Poole did not suffer from pneumoconiosis. Several factors affect the weight I place on these opinions.

Dr. Hebert's opinion is well-documented and reasoned except that I question the accuracy of the smoking history he considered. He was informed of a smoking history that would have been 29-30 years, yet other records indicate a smoking history of twice that much. Stark v. Director, OWCP, 9 BLR 1-36 (1986). The x-ray he relied on was found positive by a "B" reader and later confirmed positive by a "B" reader who is also a board-certified radiologist. Therefore, Dr. Hebert's reliance on that x-ray was certainly reasonable. Accordingly, I place some weight on his opinion. I place no weight on the diagnosis by Dr. Landers of a "history of black lung" because it is clear from the hospital records that this finding was based on the history provided to him by the miner himself. Neither of the two x-rays taken during the hospitalization when Dr. Landers attended the miner was read as positive for pneumoconiosis. Thus, Dr. Landers' diagnosis of a "history" of black lung lacks objective medical support and reliability.

I place greater weight on Dr. Emory's opinion because it is well-documented and reasoned. Perry v. Director, OWCP, 9 BLR 1-1 (1986). The x-ray on which he relied was found negative by two "B" readers and two dually certified readers. I note that he considered an exaggerated coal mine employment history, but since this error could only have aided the miner's claim, I find that it does not detract from the credibility of Dr. Emory's opinion. The opinions of Drs. Fino and Kress merit weight because they are based on a review of medical evidence which provided them with a broad base of information from which to draw their conclusions. Moreover, they possess superior qualifications in the field of pulmonary medicine. Scott v. Mason Coal Co., 14 BLR 1-38 (1990). Their conclusions are supported by the overall weight of the x-ray evidence and the examining physicians' clinical findings. Consequently, I find their opinions well-documented and reasoned.

I find the opinions of Drs. Emory, Fino, and Kress more persuasive than Dr. Hebert's, and, to the extent it is an opinion of pneumoconiosis, the conclusions of Dr. Landers. Therefore, I conclude that the credible medical opinion evidence does not tend to establish the existence of pneumoconiosis pursuant to § 718.202(a)(4).

Moreover, consideration of all the evidence under Section 718.202 also leads to the conclusion that the claimant has failed to establish the existence of pneumoconiosis by a preponderance of the evidence. Island Creek Coal Co. v. Compton, 211 F.3d 203, 22 BLR 2-162 (CRT)(4th Cir. 2000). While I found that the autopsy evidence supports a finding of pneumoconiosis, I do not consider it the strongest evidence in this case because Dr. Gabrawy's conclusion appears inconsistent with her microscopic findings. The x-ray evidence and medical opinion evidence is more convincing.

Pneumoconiosis Arising Out Of Coal Mine Employment:

Assuming, arguendo, the claimant established the existence of pneumoconiosis, he must still prove that his pneumoconiosis arose, at least in part, out of his coal mine employment. 20 C.F.R. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. Id. Because Mr. Poole worked for 14 years in coal mine employment, he is entitled to the rebuttable presumption that his pneumoconiosis, if he had it, arose out of coal mine employment.

Total Disability:

The employer's counsel stated at the hearing that the employer did not contest that Mr. Poole was totally disabled. (Tr. 21). I note that this concession is bolstered by the four pulmonary function studies of record, all of which produced qualifying values, and the six blood gas studies of record, all of which yielded qualifying results. 20 C.F.R. § 718.204(b)(2)(i) and (ii). Therefore, I find that Mr. Poole was totally disabled.

Total Disability Due to Pneumoconiosis:[14]

Unless one of the presumptions at §§ 718.304, 718.305, or 718.306 is applicable, a miner with fewer than fifteen years of coal mine employment, must establish that his or her total disability is due, at least in part, to pneumoconiosis. The Benefits Review Board has held that "[i]t is [the] claimant's burden pursuant to § 718.204 to establish total disability due to pneumoconiosis . . . by a preponderance of the evidence." Baumgartner v. Director, OWCP, 9 BLR 1-65, 1-66 (1986); Gee v. Moore & Sons, 9 BLR 1-4, 1-6 (1986) (en banc).

The Board requires that pneumoconiosis be a "contributing cause" to the miner's disability. Scott v. Mason Coal Co., 14 BLR 1-37 (1990), overruling Wilburn v. Director, OWCP, 11 BLR 1-135 (1988).

Medical opinion evidence is the only method available for a claimant to prove total disability due to pneumoconiosis. See Tucker v. Director, OWCP, 10 BLR 1-35, 1-41 (1987).
Drs. Hebert, Winkler, Landers, Zacharia, Gabrawy, and Kress did not address total disability causation. Dr. Emory opined that the miner's disability was due to fifty years of smoking. Dr. Fino also linked the miner's total disability solely to smoking. I place great weight on the opinions of Drs. Emory and Fino. Dr. Emory provided a thorough examination of Mr. Poole, and his report is well-documented. Dr. Fino reviewed all the medical evidence of record to date, and he maintains excellent credentials in the field of pulmonary diseases. Moreover, their opinions are not contradicted. Accordingly, I find that the evidence fails to establish that pneumoconiosis was a contributing cause to Mr. Poole's disability.

Survivor's Claim

Death Due to Pneumoconiosis:

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[14] The 2001 amended version of § 718.204 requires that a claimant establish that pneumoconiosis had a "material adverse effect," that is, was a "substantial cause," of his total disability. The District of Columbia Circuit Court concluded that this provision could not be retroactively applied; rather, it applies only to claims filed after January 19, 2001. National Mining Ass'n. Et al. V. Dept. Of Labor, Case No. 01-5278 (D.C. Cir. June 14, 2002). Therefore, the amended regulation is not applicable here.

In order to be eligible for benefits, Mrs. Poole must prove that her husband's death was caused by pneumoconiosis. Under § 718.205(c), death will be considered to be due to pneumoconiosis if the medical evidence establishes that pneumoconiosis was the cause of the miner's death or where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death. Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. 20 C.F.R. § 718.205(c)(5). The Benefits Review Board has held that "death will be considered to be due to pneumoconiosis where the cause of death is significantly related to or significantly aggravated by pneumoconiosis. Foreman v. Peabody Coal Co., 8 BLR 1-371, 1-374 (1985).

Survivors are not eligible for benefits where the miner's death was caused by a traumatic injury, or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4); Neeley v. Director, OWCP, 11 BLR 1-85 (1988). In order to recover benefits, Mrs. Poole must prove that the miner had pneumoconiosis, that the disease arose out of coal mine employment and that pneumoconiosis hastened her husband's death in some manner. 20 C.F.R. § 718.205(a)(1)-(3). Of course, because I have already found that the evidence fails to establish the existence of pneumoconiosis, Mrs. Poole cannot prove that the disease hastened her husband's death. Still, I will analyze the evidence under the proper standard.

The death certificate provides no assistance in this case. It was not signed by a physician, and the cause of death is listed obliquely as "unspecified natural causes." While Dr. Gabrawy diagnosed slight anthracosilicosis based on the autopsy, she did not provide an opinion as to the cause of the miner's death. The only physicians to address the cause of death are Dr. Fino and Dr. Kress. Dr. Fino opined that coal mine dust inhalation did not contribute to, cause, or hasten the miner's death. Likewise, Dr. Kress asserted that there was no evidence to suggest that pneumoconiosis hastened, caused, or contributed to the miner's death. I place great weight on these opinions because they are consistent with my finding of no pneumoconiosis, the miner's extensive smoking history, his presenting complaints, and treating physicians' physical findings. Moreover, there is no evidence in support of a finding that Mr. Poole's death was due in any way to pneumoconiosis. Consequently, I find that Mrs. Poole has failed to establish that pneumoconiosis hastened her husband's death.

Entitlement:

As the claimant-miner has failed to establish the existence of pneumoconiosis or that he was totally disabled by the disease, I find that he is not entitled to benefits under the Act. Furthermore, as the claimant-widow has failed to establish that her husband's death was due to pneumoconiosis, I find that she is not entitled to benefits under the Act.

Attorney's Fees:

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Because the benefits are not awarded in this case, the Act prohibits the charging of any attorneys' fee to the claimant for legal services rendered in pursuit of benefits.

ORDER

It is therefore **ORDERED** that the claims of Frances E. Poole and Sterling Poole for benefits under the Act are **DENIED**.

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LEE J. ROMERO, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, D.C. 20210.**